MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03317

Reg. Dist. No. 323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 14 years 9 mo. 3da.
Hospital, institution, or street address (if not in hospital) where death occurred: Peninsula Baptist Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Peninsula Baptist Home
(If rural, give LOCATION) Cor. Naylor & E. Church street
2.(a) If veteran, name war

3.(a) FULL NAME Sallie A. Amos

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9- 1853

8. AGE: Years	Months	Days	If less than one day hrs.	min.
92	2	5		

9. Birthplace Hayford County Md.
(Town, county and state)
10. Usual occupation retired
11. Industry or business at Home

MOTHER
12. Name Benjamin Amos
13. Birthplace Hayford Co. Md.

FATHER
14. Maiden name Susanna B. Robinson
15. Birthplace Hayford Co. Md.

16. Informant Rev. C. T. Peninsula Baptist Home
Address Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17-45 (month) (day) (year)
Cemetery or crematory Presbyterian Gen.
Location Highland Hayford Co. Md.

18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland.

19. 3/16/45 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 4 a. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1940 to March 14 1945
and that I last saw he alive on March 16 1945

Immediate cause of death	DURATION
Valvular Heart Disease	6 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy Results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos R Mann M. D. or other
Address Salisbury Md Date signed 3/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2370

CERTIFICATE OF DEATH

03318

Reg. Dist. No. 8 31

1. PLACE OF DEATH:
County Wicomico
City or town Helen (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, Institution, or street address where death occurred: Lillian St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Rockawalkin (If outside city or town limits, write RURAL and give nearest town)
Street No. Salisbury R. D. 2 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cernida Ellen Anderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Isaac Anderson 6.(c) If alive, give age ← years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1859

8. AGE: Years	Months	Days	If less than one day
85	3	6	hrs. min.

9. Birthplace Salisbury Wicomico Co Md (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Thomas Henry Mitchell
13. Birthplace Salisbury Md
MOTHER 14. Maiden name Sarah E. White
15. Birthplace Salisbury Md
16. Informant Isaac Anderson Husband
Address Salisbury Md R. D. 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 7 45 (month) (day) (year)
Cemetery or crematory Rockawalkin Cemetery
Location Rockawalkin Md
18. Funeral director The Hill & Johnson
Address Salisbury Md
19. Mch 5 1945 (Date rec'd by registrar) Mrs J M Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945 at 10.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20th 1945 to March 2nd 1945 and that I last saw alive on March 2nd 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions Chronic Myocarditis Chronic Nephritis (Include pregnancy within 3 months of death)	

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Enrid M. D. or other
Address Helen - Md Date signed March 5th 1945

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MD 03319

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 733

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Accomack

City or town Chincoteague
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME Aaron Stemy Aydelotte

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bessie Aydelotte

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 1883

8. AGE: Years	Months	Days	If less than one day
52	11	29	hrs. min.

9. Birthplace Chincoteague Va
(Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business

FATHER
12. Name Aaron Stemy Aydelotte
13. Birthplace Chincoteague Va

MOTHER
14. Maiden name Josephine Alice Read
15. Birthplace Chincoteague Va

16. Interment Bessie Aydelotte
Address Chincoteague Va

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof March 18 1945
(month) (day) (year)

Cemetery or crematory Chincoteague Va

Location Chincoteague Va

18. Funeral director Walter M Lelands

Address Chincoteague Va

19. 3/17/46 (Date rec'd by registrar) Maggie L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from [illegible] 19 to [illegible] 19 and that I last saw [illegible] alive on [illegible] 19

Immediate cause of death	DURATION
Fractured Neck	sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-15-45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Car struck pole Injured at work? No

Jas Rademaky MD

23. SIGNATURE Deputy Med Examiner M. D. or other

Address Salisbury Md Date signed 3/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

03329

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr
Hospital, Institution, or street address where death occurred: P. G. Hospital
How long in hospital or institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No. Eden Md R D 2
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Banks

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single ✓

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): June 20, 1862

8. AGE: Years	Months	Days	If less than one day
82	8	10	..... hrs. ..... min.

9. Birthplace: Wicomico Co Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
12. FATHER Name: Thomas Banks
13. FATHER Birthplace: Wicomico Co Md
14. MOTHER Maiden name: Jane Bivins
15. MOTHER Birthplace: Wicomico Co Md.
16. Informant: Mrs James Henson
Address: Eden Md, R. D. 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)
Cemetery or crematory: Henson Cemetery
Location: Eden, Md R. D 2
18. Funeral director: W. Hill & Johnson
Address: Salisbury, Md
19. 3/6 19 45 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 19 45, at 9:30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19 ..... to ..... 19 ..... and that I last saw ~~him~~ alive on ..... 19 .....

Immediate cause of death	DURATION
~~Fall downstairs~~	sudden death
Due to Concussion of Brain	"
Due to Fall downstairs	"
Due to Cardiac Syncope	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 3/1/45
Where did injury occur? Eden (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Fell downstairs Injured at work? No
after fainting

23. SIGNATURE: [illegible] Medical Examiner M. D. or other
Address: Salisbury Md Date signed 3/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 76

03321

CERTIFICATE OF DEATH

Reg. Diat. No. 331

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury RFD # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years near Hebron
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury near Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Harvey Bradley

3.(b) Social Security Number -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Alpha B.Bradley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb.4-1869

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Sussex County, Delaware
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business Farm

FATHER
12. Name Samuel J.Bradley
13. Birthplace Sussex County, Delaware

MOTHER
14. Maiden name Lucretia Walson
15. Birthplace Sussex County, Delaware

16. Informant Miss Annie Bradley
Address Salisbury, Md. RFD # 2

17. Burial (Burial, cremation, or removal/Which?) Date thereof April 2, 1945 (month) (day) (year)
Cemetery or ~~cemetery~~ Mt. Pleasant
Location Laurel, Delaware

18. Funeral director W.B. Gravel Co
Address Seldmore Delaware

19. Mch 31 1945 Mrs J Mueller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1945 at 4.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch. 31 1945, to Mch 31 1945
and that I last saw h... alive on Mch 30 1945

Immediate cause of death	DURATION
Internal Abdominal Hemorrhage Due to ruptured aortic Aneurysm	2 hours
Due to Aneurism of Abdominal Aorta	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J.T. Tyndall M. D. or other
Address Salisbury Md. Date signed Mch 31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03322

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico Co
County
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: Ocean City Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ocean City Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Franklin Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary C. Brown
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.): March 22-1882

8. AGE: Years	Months	Days	If less than one day
63		3	hrs. min.

9. Birthplace: Lawrence Mass
(Town, county, and state)
10. Usual occupation: Medical Doctor
11. Industry or business:

FATHER
12. Name: Vincent Brown
13. Birthplace: Mass.

MOTHER
14. Maiden name: Margaut Hearn
15. Birthplace: Mass.

16. Informant: Mrs. Mary C. Brown
Address: Ocean City Road, Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 27-45 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Maryland

18. Funeral director: Holloway & C. Walter R. Holloway
Address: Salisbury Maryland.

19. 3/27/45 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25th 1945, at 950 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 to [illegible] 19 and that I last saw h[illegible] alive on [illegible] 19

Immediate cause of death	DURATION
Coronary Thrombosis	4 hours Death
Due to Angina Pectoris	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L A Radcliffe M.D. Deputy Med Examiner
M. D. or other
Address Salisbury, Md Date signed 3/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03323

CERTIFICATE OF DEATH

Reg. Diat. No. 336

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar RFD # 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: New Castle
City or town: Wilington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1323 Shallcross Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Francis J. Canning

3.(b) Social Security Number: 221-05-3935

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Canning
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 28, 1875

8. AGE: Years	Months	Days	If less than one day
69			hrs. min.

9. Birthplace: Queene Anne, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Cris Collins
Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28-45 (month) (day) (year)
Cemetery or crematory: XXXXX M.E.
Location: Delmar, Delaware

18. Funeral director: W. S. Mansel Co
Address: Delmar Delaware

19. 3-28-45 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26th 1945 at 4.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from At intervals 2 yrs to 19
and that I last saw h alive on May 26 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 6 hours
with general paralysis
Due to: Hypertension & Obesity — 3 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other
Address: Delmar, Del. Date signed: 3-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160)

03324

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula Gen Hosp.
How long in hospital or institution? 1 hr 27 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1005 Market Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Card

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

8.(b) Name of husband or wife: - - - - - - - -
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 11, 1945

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 27 min.

9. Birthplace: Salisbury Md.
(Town, county, and state)
10. Usual occupation: - - - - -
11. Industry or business: - - - - -
FATHER 12. Name: Charles Ramsey Card
13. Birthplace: Vina, Alabama
MOTHER 14. Maiden name: Harriett McClung
15. Birthplace: Jumping Branch, West Virginia
16. Informant: Mrs. Harriett Card
Address: 1005 Market Street Pocomoke Md
17. Cremation (Bnrial, cremation, or removal. Which?) Date thereof March 13 1945 (month) (day) (year)
Cemetery or crematory: [illegible]
Location: Peninsula General Hospital
18. Funeral director: Peninsula General Hospital (or person acting as)
Address: Salisbury, Md.
19. 3/12/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 19 45 at 10:30 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/11 19 45 to 3/11 19 45
and that I last saw h[illegible] alive on 3/11 19 45

Immediate cause of death	DURATION
Premature Birth 5 mos	
Due to Premature Separation of Placenta	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Grace R Mann M. D. or other
Address: Salisbury Md Date signed 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03325

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred: 301 W. Main St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 301 W. Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Love Coates

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles P. Coates
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26, 1868

8. AGE:

Years	Months	Days	If less than one day
76	11	8	hrs. min.

9. Birthplace: Phila. Penna.
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: Charles Henry Love
13. Birthplace: Phila. Penna.

MOTHER
14. Maiden name: Rebecca Rand Edward
15. Birthplace: Phila. Penna.

16. Informant: Mrs. Howard Pinnix
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md.
18. Funeral director: The Hall-Johnson Co.
Address: Salisbury Md.

19. 3/6 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 1945, at 8 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.., to January 4 1945 and that I last saw h.. alive on January .., 1945.

Immediate cause of death	DURATION
carcinoma thyroid	2 yr.
Due to: Metastases lungs	1/2 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other
Address: Salisbury Md. Date signed: Mar 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06 03324

Reg. Dist. No. 353

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, Institution, or street address where death occurred:
Peninsula Hospital
How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Wantagh, Long Island N.Y.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Woodland ave. P.O. Box 488
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME William John Crawford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie B. Crawford
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): March 2-1880

8. AGE:

Years	Months	Days	If less than one day
65	0	23	hrs. min.

9. Birthplace: Chicago, Ill. (Town, county, and state)
10. Usual occupation: General Foreman
11. Industry or business: Water & Engineering C. Phila, Pa

FATHER
12. Name: William Crawford
13. Birthplace: Utah

MOTHER
14. Maiden name: Mary Patton
15. Birthplace: Chicago, Ill.

16. Informant: Mrs. Jennie B. Crawford
Address: P.O. Box 488 Wantagh, Long Island N.Y.
17. Burial, cremation, or removal. Which? Burial Woodland Ave. Date thereof: May 28-45
(Burial, cremation, or removal) (month) (day) (year)
Cemetery or crematory: St. Johns Cem.
Location: Astoria, Long Island N.Y.
18. Funeral director: Holloway & G. Walter R. Holloway
Address: Salisbury Maryland.
19. 3/28/45 1945 Margaret E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-25 1945, at 1 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-18 1945 to 3-25 1945 and that I last saw him alive on 3-25 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
c cerebral & pulmonary	
Due to (a) embolism:	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?
23. SIGNATURE: Hollis G Holloway M. D. or other
Address: Salisbury, Md. Date signed 3-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

03327

Reg. Dist. No. X336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

100 Pine Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 Pine Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Virgie Tyndall Culver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louie Culver

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): September 26, 1892

8. AGE:	Years	Months	Days	If less than one day
	52			....hrs. ....min.

9. Birthplace: Salisbury, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Levin I Tyndall

FATHER — 13. Birthplace: Wicomico County, Md.

MOTHER — 14. Maiden name: Ida Pierre

MOTHER — 15. Birthplace: Wicomico County, Md.

16. Informant: Louie Culver

Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 10-45 (month) (day) (year)

Cemetery or Crematory: M.P.

Location: Delmar, Delaware

18. Funeral director: W. S. Morris Co

Address: Delmar, Delaware

19. 3/10 - 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: March 7 1945 at 11.53 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944, to Mar 7 1945

and that I last saw h... alive on Dec 1944

Immediate cause of death	DURATION
Acute cardiac failure due to infarction angina attacks	24 hrs.
Due to Coronary Sclerosis	5 yr.
Due to Chronic Nephritis	6 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Tyndall M. D. or other

Address: Delmar Del. Date signed: Mar 9 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13328

Reg. Dist. No. 332

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred: Willards
How long in hospital or institution? Mar. 4 until 16

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie M. Davis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Levin J. Davis
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Feb. 29, 1872

8. AGE:

Years	Months	Days	If less than one day
73	1	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: general farm wife
11. Industry or business
12. FATHER — Name: Elisha Mitchel
13. FATHER — Birthplace: Dely
14. MOTHER — Maiden name: Nettie Baker
15. MOTHER — Birthplace: Md.
16. Informant: Levin Mitchel Davis
Address: Willards Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1-1945 (month) (day) (year)
Cemetery or crematory: Private Delmar
Location: Powellville R.D.
18. Funeral director: Mrs M. Pasha Watson
Address: Selbyville Del.
19. Apr. 1 1945 (Date rec'd by registrar) Lillian R. Dana Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1945 at 12 M.P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 25 1945, to day of death
and that I last saw her alive on 3-29-45 1945
Immediate cause of death: Carcinoma of liver — DURATION: 5 weeks
Due to: age (at) operation of breast
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place, (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Lewis M.D. M. D. or other
Address: Willards Md Date signed 4-1-45

03329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred: 412 Lemmon(?) ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Anne Davis

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Charles E. Davis
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) Nov. 26-1884

8. AGE: Years 60 Months 4 Days 3 If less than one day ... hrs. ... min.

9. Birthplace Worcester Co. Md. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business at Home
FATHER 12. Name James Smullens(?)
13. Birthplace Worcester Co. Md.
MOTHER 14. Maiden name Hennie Truitt
15. Birthplace Worcester Co. Md.
16. Informant Mr. Charles E. Davis
Address R.D. #1. Salisbury Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1-45 (month) (day) (year)
Cemetery or crematory Wicomico Mem. Park
Location Salisbury Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland
19. 4/1/ 19 45 (Date rec'd by registrar) Haskell(?) E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th 19 45, at 10.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 45, to Mar 29 19 45
and that I last saw her alive on Mar 29 19 45

	DURATION
Immediate cause of death: Acute Vab(?) Heart-	2 weeks(?)
Due to Chr. Int. Nephritis	2 yrs
Due to Hypertension	2 yrs
Other conditions Arter(?) Sclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. D. Dacey(?) M.D. M.D. or other
Address Fruitland Md. Date signed 3/31/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

(13331)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Harold L Dennis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Husband

6.(b) Name of husband or wife: Bessie Dennis

6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Feb 12 about 1896

8. AGE:

Years	Months	Days	If less than one day
about 49			..... hrs. ..... min.

9. Birthplace: Allen Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: William Dennis
13. Birthplace: Princess Anne Md

MOTHER
14. Maiden name: Elizabeth Peters
15. Birthplace: Pricetland Md

16. Informant: Elizabeth Peters
Address: Allen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1945 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Allen Md

18. Funeral director: James F Stewart

Address: Salisbury Md

19. 3/13 1945 (Date rec'd by registrar) Harriet L Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 - 11 1945, at 12 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..

and that I last saw him alive on ..... 19..

Immediate cause of death: Bullet wound of chest — DURATION: sudden death

Due to: .....

Due to: .....

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: Autopsy

Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 3-11-45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Shot by unknown assailant Injured at work? No

23. SIGNATURE: [illegible] Deputy Health Examiner M. D. or other

Address: Salisbury, Md Date signed 3/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No G 94 MAY 16 1945.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03331

Reg. Dist. No. 3321

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Isaac Henry Dennis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida May Dennis
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 16, 1866

8. AGE: Years: 78 | Months: 9 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Willards, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Thomas Dennis
13. Birthplace: Md.

MOTHER
14. Maiden name: Morgonett (Unknown)
15. Birthplace: Md.

16. Informant: Mrs. Ida May Dennis
Address: Willards, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 27 1945 (month) (day) (year)
Cemetery or crematory: Mt. Pleasant.
Location: Willards, Md.

18. Funeral director: M. Pasha Watson
Address: Salisbury, Md.

19. Mar. 27 1945 (Date rec'd by registrar) Lillian L. Shaw Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-25-45 19... at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1944 to day of death.
and that I last saw him alive on 3-24-45 19...

Immediate cause of death	DURATION
Chronic nephritis.	2 yrs.
Hyp. Hypertension	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Lewis M.D.
M. D. or other
Address: Willards Md Date signed: 3-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (850)

CERTIFICATE OF DEATH

(13332) Reg. Dist. No. 331

1. PLACE OF DEATH:
County: Wicomico
City or town: Hebron (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Olive Dickerson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Married

6.(b) Name of husband or wife: Mary J. Dickerson
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): December 4, 1879

8. AGE:

Years	Months	Days	If less than one day
65	3	15	hrs. min.

9. Birthplace: Mardela Springs, Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business
12. FATHER — Name: Dennis Dickerson
13. FATHER — Birthplace: Mardela Springs, Md.
14. MOTHER — Maiden name: Mckenzie
15. MOTHER — Birthplace:
16. Informant: Mrs. Mary J. Dickerson
Address: Hebron, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/45 (month) (day) (year)
Cemetery or crematory: Mardela Springs Cem.
Location: Mardela Springs Md.
18. Funeral director: Mrs. C. B. McQuick & Sons
Address: Hebron, Md.
19. March 18 19 45 (Date rec'd by registrar) Mrs J M Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1945, at 7.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945 to March 15 1945 and that I last saw him alive on March 14 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	1
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Millicent Emrich M. D. or other
Address: Hebron Md. Date signed: March 18

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03333

Reg. Diat. No. 393

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 29 d

Hospital, Institution, or street address where death occurred:

E.S. #B Sanatorium

How long in hospital or institution? 1 mo 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Nelson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Tilden Hendricks Eller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Ella Mary Eller

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Jan 11, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	27	..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business:

FATHER

12. Name: unknown

13. Birthplace:

MOTHER

14. Maiden name: Polly Minton

15. Birthplace: North Carolina

16. Informant: deceased on admission

Address: Nelson, Md. R.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/11/45 (month) (day) (year)

Cemetery or crematory: Nelson

Location: Nelson, Md.

18. Funeral director: H. Hill Johnson Co.

Address: Salisbury, Md.

19. 3/11/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1945, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/19/45 19.. to 3/8/45 19..

and that I last saw h.. alive on 3/2/45 19..

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Carroll Allen, M.D. (M. D. or other)

Address: Salisbury Date signed: 3/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

03334

CERTIFICATE OF DEATH

Reg. Dist. No. 11 336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

611 Chestnut Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 Chestnut

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Della Mae Ellis

3.(b) Social Security Number ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife Riley Ellis

6.(c) If alive, give age ----

7. Birth date of deceased (mo., day, yr.) Dec.11- 1875

8. AGE:	Years	Months	Days	If less than one day
	69			....hrs. ....min.

9. Birthplace Wicomico County, Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Matilda Littleton

15. Birthplace Wicomico County, Md.

16. Informant William J. Ellis

Address Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 9-45 (month) (day) (year)

Cemetery or crematory Libertytown

Location Libertytown, Maryland

18. Funeral director W. S. Jarrell Co

Address Delmar, Delaware

March 7 1945 Harry E. Hudson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945 at 7 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1944 to Mar 7 1945

and that I last saw her alive on Mar. 7 1945

	DURATION
Immediate cause of death Acute Cardiac Failure	24 hrs
Due to Carcinoma of stomach	2 yr
Due to Pneumonia Bilateral	10 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Tyndall M. D. or other

Address Delmar Date signed Mar 7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03335

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 202 Maryland ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 202 Maryland ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Susie H Fleming

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William S. Fleming
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 30, 1882

8. AGE: Years	Months	Days	If less than one day
62	4	27	hrs. min.

9. Birthplace: Princess Anne, Somerset Co, Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: John S. Bardley
13. Birthplace: Wicomico Co, Md

MOTHER
14. Maiden name: Emma Adams
15. Birthplace: Somerset Co, Md

16. Informant: Mrs Frances Bunyon
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/30/45 (month) (day) (year)
Cemetery or crematory: Baptist M. E. Cemetery
Location: Parsonage Md
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury Md
19. 3/30 1945 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1945 at 10 30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1944 to March 27 1945
and that I last saw h.e.r. alive on March 27 1945

Immediate cause of death	DURATION
Carcinoma Uterus	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: R. 1, Box 5 Quantico Md Date signed: 3-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-R)

CERTIFICATE OF DEATH

03336

Reg. Diat. No. 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Vienna Road

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Vienna Road

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Lorraine Emma Gattis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 19, 1941

8. AGE: Years	Months	Days	If less than one day
3	10	25	...hrs. ...min.

9. Birthplace Mardela Springs, Maryland, R.F.D. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

FATHER

12. Name Otto Gattis

13. Birthplace Tyaskin, Maryland

MOTHER

14. Maiden name Nettie Deshields

15. Birthplace Wicomico County, Maryland

16. Informant Otto Gattis

Address Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 16, 1945 (month) (day) (year)

Cemetery or crematory Mardela Colored Cemetery

Location Mardela Springs Maryland R.F.D.

18. Funeral director J.J. Trampton and Son

Address Federalsburg, Maryland

19. 3/16/45 (Date rec'd by registrar) 19.. W.H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased from~~ ... 19.. to ... 19.. and that I last saw ~~him~~ her alive on ... 19..

Immediate cause of death	DURATION
Retroperitoneal Sarcoma	6 mos.
Due to	
Due to	
Other conditions Generalized metastases	

(Include pregnancy within 3 months of death)

Major findings of operations None

... Date of op. ...

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Salisbury Md Deputy Coroner M. D. or other

Address Salisbury Md Date signed 3/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03337

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 Market
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mr. Abraham Groh.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

8.(b) Name of husband or wife: Sarah Wodensky Groh
Died Oct 17, 1940
8.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): 1866

8. AGE:

Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Clothing Manufacturing
FATHER — 12. Name: Jacob Groh
FATHER — 13. Birthplace: Russia
MOTHER — 14. Maiden name: unknown.
MOTHER — 15. Birthplace:
16. Informant: Maurice Groh. Address: 505 Market St Pocomoke Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28-45 (month) (day) (year)
Cemetery or crematory: Jewish Cem New Bedford Mass
Location: New Bedford Mass
18. Funeral director: Hellwig & Walter R. Hellwig
Address: Salisbury Maryland.
19. (Date rec'd by registrar) 3/27/45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1945, at 8:17 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1945 to March 27 1945 and that I last saw h. alive on March 27 1945

Immediate cause of death	DURATION
Fractured Rt Hip	3 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Fractured Rt hip. Date of op. 3-15-45
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 3-6-45
Where did injury occur? Pocomoke (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?): Street.
Means of injury: Fell down. Injured at work? No

23. SIGNATURE: Sarah Rademacher MD Deputy Medical Examiner (M. D. or other)
Address: Salisbury Md Date signed: 3/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03338

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5-2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill Rural #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) 70

2.(a) If veteran, name war

3.(a) FULL NAME James Valentine

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) — — 1863

8. AGE: Years 82 | Months | Days | If less than one day hrs. min.

9. Birthplace Snow Hill Worcester Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Jane Ratledge

15. Birthplace Maryland

16. Informant Miss Lottie E. Hudson

Address Snow Hill, Md Rural #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26/45 (month) (day) (year)

Cemetery or crematory Bates Methodist

Location Snow Hill, Md

18. Funeral director Deane & Timmons

Address Snow Hill, Md

19. 3/26 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/31 1945 to 3/24 1945 and that I last saw h alive on 3/24 1945

Immediate cause of death	DURATION
Hypertrophied Prostate	Unk
Due to	
Due to	
Other conditions Chr. Nephritis	Unk

(Include pregnancy within 3 months of death)

Major findings of operations Hypertrophied Prostate Date of op. 3/14/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Nichols M. D. or other

Address Salisbury Date signed 3/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-d)

03339

CERTIFICATE OF DEATH

Reg. Dist. No. H 336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: 3 miles south of Quantico

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Germany County:

City or town: Warstein

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 12 Horst Wessel St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War No. II

3.(a) FULL NAME: Franz Herberhold, Gefr., 31G 130505

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
21	11			

8. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Camp Somerset, Westover, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7 1945 (month) (day) (year)

Cemetery or crematory: Fort George Meade,

Location: Fort George G. Meade, Maryland

18. Funeral director: W. S. Mapel Co.

Address: Delmar, Delaware

March 5 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 March 1945 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Hemorrhage and shock, acute, traumatic, severe. — DURATION

Due to: laceration penetrating, through left abdomen and pelvis. Fracture

Due to: compound, comminuted left humerus.

Injuries sustained 5 March 45, 11:45 a.m.

Other conditions: when patient was drawn into a sawmill, near Quantico, Md.

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~Suicide, Homicide~~: Date of 5 March 45

Where did injury occur? Quantico, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Lumber Project

Means of injury: Circular saw Injured at work? Yes

HARVEY M. PARKER, Deputy Medical Examiner in Somerset County

23. SIGNATURE: Harry M. Parker M.D. M. D. or other

Address: Princess Anne, Md. Date signed: 3/6/45

03340

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs
Hospital, institution, or street address where death occurred: 420 Oak Hill Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 420 Oak Hill Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lois Beatrice Hill
3. (b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Walter Hill
6.(c) If alive, give age 39 years
7. Birth date of deceased (mo., day, yr.) Dec. 11 - 1911
8. AGE: Years 33 Months Days If less than one day hrs. min.
9. Birthplace Salisbury Md. (Town, county, and state)
10. Usual occupation Home wife
11. Industry or business
FATHER 12. Name John H. Niblett
13. Birthplace Whaleyville Md.
MOTHER 14. Maiden name Sarah E. Donaway
15. Birthplace Whaleyville Md.
16. Informant Mrs. Sarah E. Niblett
Address 420. Oak Hill Ave. Salisbury Md.
17. Burial (Burial, cremation, or removal (Which?)) Date thereof Mar. 30 45 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md.
18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Md.
19. 3/30/45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 - 19 45 at 9:30 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to Mar 28 1945 and that I last saw h er alive on March 27 1945
Immediate cause of death General asthenia — DURATION few wks
Due to T. B. of lungs — 4 months yrs
Due to Had only been home from sanatorium for few weeks
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE [illegible] M. D. or other
Address Salisbury Md. Date signed Mar 28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

03341

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, R.D. 5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury, R.D. 5
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edith Bounds Kitts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert F. P. Kitts
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.): July 17, 1875.

8. AGE: Years 69 | Months 7 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace: Wicomico Co., Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: John Henry Bounds
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Elizabeth King
15. Birthplace: Wicomico Co., Md.

16. Informant: Howard C. Kitts
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/9/45 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury, Md.

18. Funeral director: De Witt Johnson Co.
Address: Salisbury, Md.

19. 3/9/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1945, at 7.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1, 1944, to March 7, 1945
and that I last saw h[illegible] alive on March 7, 1945

Immediate cause of death	DURATION
Carcinoma of Rectum	Late
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Rectum
Date of op. Nov 11 1944
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13342

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Laurel Del
(If outside city or town limits, write RURAL and give nearest town)
Street No.: na
(If rural, give LOCATION)
2.(a) If veteran, name war: na

3.(a) FULL NAME: Catherine Jacobs

3.(b) Social Security Number: Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C	Married

6.(b) Name of husband or wife: Edward Jacobs
If alive, give age: yes Don't know years

7. Birth date of deceased (mo., day, yr.): about 1920

8. AGE: Years	Months	Days	If less than one day
about 26			..... hrs. ..... min.

9. Birthplace: U.S.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER
12. Name: Hezekiah Moore
13. Birthplace: U.S.

MOTHER
14. Maiden name: Hattie Moore
15. Birthplace: U.S.

16. Informant: Hezekiah
Address: Laurel Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8 1945 (month) (day) (year)
Cemetery or crematory: Laurel
Location: Laurel Del

18. Funeral director: James H. Stewart
Address: Salisbury md

19. 3/8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1945 at 11:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Streptococcus Peritonitis	
Due to Pelvic Inflammatory Disease ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Acute P.I.D
Peritonitis Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: P Insley M.D. F.A.C.S.
M. D. or other
Address: Salisbury Date signed 3/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

03343

Reg. Diat. No. 331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Johson, woodrow

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 16 1919

8. AGE: Years: 26 | Months: y | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Columbia S. C. (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER — 12. Name: Fred Johnson

FATHER — 13. Birthplace: Columbia S. C.

MOTHER — 14. Maiden name: Leggie Butler

MOTHER — 15. Birthplace: Columbia S. C.

16. Informant: James Butler

Address: Quantico Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: 3/7/45 (month) (day) (year)

Cemetery or crematory: Quantico Cem.

Location: Quantico Md.

18. Funeral director: Mrs C. Messick Sons

Address: Nelson Md.

19. Mch 7 1945 (Date rec'd by registrar) Mrs J. M. Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 - 4 1945 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw ..... alive on ..... 19.....

Immediate cause of death: Internal Hemorrhage — DURATION: under 1 hr death

Due to: Bullet wound of Superior Vena Cava

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.

Autopsy results: None above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: 3/4-45

Where did injury occur? Quantico (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: shot by other Injured at work? No

23. SIGNATURE: Forwarded by Deputy Med Examiner M. D. or other

Address: Salisbury Md Date signed: 3/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03344

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Jones

3.(b) Social Security Number: 218-05-8786

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Georgia Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 19, 1898

8. AGE: Years	Months	Days	If less than one day
46	8	16	..... hrs. ..... min.

9. Birthplace: Princess Anne Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John L. Jones

FATHER — 13. Birthplace: Somerset Co.

MOTHER — 14. Maiden name: Amanda Curtis

MOTHER — 15. Birthplace: Somerset Co.

16. Informant: Georgia Jones

Address: Princess Anne Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-8-1945 (month) (day) (year)

Cemetery or crematory: Mt Carmel

Location: Princess Anne, Md.

18. Funeral director: William Jones & Son

Address: Princess Anne, Md.

19. 3/8 1945 (Date rec'd by registrar) Margaret L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1945; at 6:28 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h... alive on ..... 19..

Immediate cause of death: Apoplexy — DURATION: sudden

Due to: — DURATION:

Due to: — DURATION:

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Elmer T. Fassbender Jr. Deputy Medical Examiner M.D. or other

Address: Salisbury Md. Date signed: 3-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

03345

CERTIFICATE OF DEATH

Reg. Diat. No. 833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred: 124 Lincoln ave. (Priatt Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: 114 Lincoln Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maggie Pauline Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Benjamin Thomas Jones
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): May 5- 1876

8. AGE: Years 68 | Months 10 | Days 3 | If less than one day: hrs. min.

9. Birthplace: Quincy Ill. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: Conrad Sterling
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Pauline Ette
15. Birthplace: France

16. Informant: Mrs. Pauline Brown
Address: 114 Lincoln ave. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 11-45 (Month) (day) (year)
Cemetery or crematory: Parsonsburg Church Cem.
Location: Parsonsburg, Maryland

18. Funeral director: Holloway & Nelson R. H. Fleming
Address: Salisbury Maryland

19. 3/11/45 (Date rec'd by registrar) 19 /46 Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8th 19 45 at 455 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44, to March 8th 19 45; and that I last saw h[illegible] alive on March 8th 19 45

Immediate cause of death	DURATION
Uremia	4 days
Due to: Hypertension	1 year
Due to: Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles M. Brown M. D. Jr. M. D. or other
Address: Salisbury Md. Date signed 3/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(13346

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred: Ocean City Road R.D. 3
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ocean City Road R. D 3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John W. Justice

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Estelle W. Justice
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Feb 10, 1892

8. AGE: Years	Months	Days	If less than one day
53	0	19	...hrs. ...min.

9. Birthplace: Accomac Co Va. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Frank E. Justice
13. Birthplace: Accomack Co Va.
MOTHER 14. Maiden name: Annie L. Warner
15. Birthplace: Accomac, Co Va.
16. Informant: Mrs John W. Justice
Address: Salisbury, Md. R.D.3.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/4/45 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury Md
18. Funeral director: The Hill & Johnson Co
Address: Salisbury, Md
19. 3/4/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 19 45 - at 7 50 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 19 44 - to March 1 19 45 -
and that I last saw him alive on ... 19...
Immediate cause of death: Cancer of Pancreas — DURATION: 2 mos
Due to: ...
Due to: ...
Other conditions: ...
(Include pregnancy within 3 months of death)
Major findings of operation: Operation Nov 19 44 Cancer of pancreas ... Date of op Nov 19 44
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Charles M. Brown Jr. M.D. (M. D. or other)
Address: Salisbury Md Date signed 3/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

03347

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Allen (If outside city or town limits, write RURAL and give nearest town) md
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Allen (If outside city or town limits, write RURAL and give nearest town) md
Street No.: no (If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME Esther Annie King

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a-a	Widow

6.(b) Name of husband or wife: Scott King
8.(c) If alive, give age: [illegible] years

7. Birth date of deceased (mo., day, yr.): about 1879

8. AGE: Years	Months	Days	If less than one day
about 69			hrs. min.

9. Birthplace: Allen md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: no

FATHER
12. Name: George Brewington
13. Birthplace: Allen md

MOTHER
14. Maiden name: Martha Pillatt
15. Birthplace: Allen md

16. Informant: Truman King
Address: Allen md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 16-1945 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Allen, md
18. Funeral director: James F. Stewart
Address: Salisbury md

19. 3/16 1945 Harriet L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1945 at 6:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1945 to March 13 1945
and that I last saw h.e.r. alive on March 9 1945

Immediate cause of death	DURATION
Progressive Bulbar Paralysis	3 Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elsie L. Mansman M. D. or other
Address: Ames md Date signed: 3.15.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

03348

CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico
County: Salisbury
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred: 303 Truitt St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Truitt St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elsie Florence Lewis

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Phillip R. Lewis
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): Dec. 10- 1896

8. AGE: Years: 48 Months: 3 Days: 20 If less than one day: hrs. min.

9. Birthplace: Worcester Co. Md. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: Manain Hitchens
13. Birthplace: Millsboro Delaware

MOTHER
14. Maiden name: Mary E. Cranfield
15. Birthplace: Millsboro Delaware

16. Informant: Mr. Phillip R. Lewis
Address: 303 Truitt St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 3-45 (month) (day) (year)
Cemetery or crematory: Evergreen Cem.
Location: Berlin Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 3-31-1945 (Date rec'd by registrar) Harriet E. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30th 1945 at 1220 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1945 to March 30 1945 and that I last saw h. alive on March 30 1945

Immediate cause of death	DURATION
Valvular Heart Disease	Unknown
Due to	
Due to	
Other conditions: Heart was weakened by attack Pneumonia 2 weeks ago (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hiram R. Moore M. D. or other
Address: Salisbury Md. Date signed 3/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

03349

Reg. Diat. No. 330

1. PLACE OF DEATH

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred: Parsonage Baptist Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Parsonage Baptist Home

(If rural, give LOCATION)

Cor. Naylor & Church streets

2.(a) If veteran, name war

3. (a) FULL NAME Addie Livingston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife James E. Livingston Dead

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1858

8. AGE: Years	Months	Days	If less than one day
87	1	15	..... hrs. ..... min.

9. Birthplace Albany Co. Rensselaerville N.Y.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business at Home

FATHER 12. Name Nathaniel Borthwick

13. Birthplace Near Middleburg N.Y.

MOTHER 14. Maiden name Roxanna Griffen

15. Birthplace Albany Co. N.Y.

16. Informant Mr. William Cook

Address Cobleskill N.Y.

17. Burial (Burial, cremation, or removal, which?) Date thereof May 7-45 (month) (day) (year)

Cemetery or crematory Schoharie Cemetery

Location (Near) Cobleskill N.Y.

18. Funeral director Holloway & G. Walter R. Holloway

Address Salisbury Maryland

19. 3/3/45 (Date recd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to March 2 1945

and that I last saw her alive on March 2 1945

Immediate cause of death	DURATION
Pneumonia (Lobar)	1 day
Due to	
Due to	
Other conditions Valvular Heart Disease	Unknown
Mumps Rheumatism	4 mos

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Howard R. Mann M. D. or other

Address Salisbury Md. Date signed 3/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

(13351)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred: U.S. Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Nelson (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Blanche Messick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: A. Steuart Messick
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1878

8. AGE: Years	Months	Days	If less than one day
66	3	4	hrs. min.

9. Birthplace: Metropolis Wicomico Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John W. Hamblin
13. Birthplace: Metropolis, Md.
MOTHER 14. Maiden name: Esther E. Mitchell
15. Birthplace: Metropolis Md.
16. Informant: A. Steuart Messick
Address: Metropolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/45 (month) (day) (year)
Cemetery or crematory: Metropolis Cemetery
Location: Metropolis Md.
18. Funeral director: Mrs. C. Messick Davis
Address: Nelson Md.
19. 3/19 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1945, at 12:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1945 to March 19, 1945 and that I last saw h[illegible] alive on March 19, 1945

Immediate cause of death	DURATION
cerebral hemorrhage	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Brewington M.D. M. D. or other
Address: Salisbury Md. Date signed: March 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03351

Reg. Dist. No. 11 336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: North Carolina County: Pitt

City or town: Farmville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD # 1
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: Jessie Belle Moran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: L.G.Moran

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): January 15,1922

8. AGE:	Years	Months	Days	If less than one day
	23	2	1	....hrs. ....min.

9. Birthplace: Rocky Mounty, N.C.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER

12. Name: Chas. Parisher

13. Birthplace: Martin,County, N.C.

MOTHER

14. Maiden name: Sallie Lasiter

15. Birthplace: Martin County, N.C.

16. Informant: Chas. Parisher

Address: Farmville, N.C. RFD # 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar.20-45 (month) (day) (year)

Cemetery or crematory: XXX Forest Hill

Location: Farmville, N.C.

18. Funeral director: W. S. Marvel Co.

Address: Delmar, Delaware

19. March 17, 1945 (Date rec'd by registrar) Harry E. Hudson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-16 1945, at 8 11/ p. M.

21. I CERTIFY that death occurred on the date above stated; that I ~~attended deceased from~~ medical examiner autopsied 19.... to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death: Fractured skull compound — DURATION: Sudden death

Due to:

Due to:

Other conditions: Co. Fracture Rt leg
(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident — Date of: 3-16-45

Where did injury occur? near Delmar (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Pedestrian struck by car. Injured at work? no

23. SIGNATURE: [illegible] Deputy Med. Exam. M. D. or other

Address: Salisbury, Md.

Date signed: 3/18/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

03352

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 113 E. Isabella St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 113 E. Isabella St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosa Lee Morris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert F. Morris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 24, 1856

8. AGE: Years	Months	Days	If less than one day
88	8	1	....hrs. ....min.

9. Birthplace: Wicomico Co. Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER — 12. Name: John Tilghman
13. Birthplace: Wicomico Co. Md.
MOTHER — 14. Maiden name: Sarah Davis
15. Birthplace: Wicomico Co Md
16. Informant: Miss Ida Morris
Address: Salisbury, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md.
18. Funeral director: The Hill & Tilghman Co.
Address: Salisbury, Md.
19. 3/27/45 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945 to March 25 1945
and that I last saw h[illegible] alive on March 11, 1945

Immediate cause of death	DURATION
Uraemia	
Due to: Cardio vascular renal disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. A. Tilghman M. D. or Other
Address: Salisbury Md. Date signed 3-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

CERTIFICATE OF DEATH

03353

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 mo.

Hospital, Institution, or street address where death occurred: R.D. #1.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Larenia Jane Mumford

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Female	White	Married.

6.(b) Name of husband or wife John Thomas Mumford

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept. 22nd 1887

8. AGE: Years	Months	Days	If less than one day
57	5	23	..... hrs. ..... min.

9. Birthplace Parsonsburg Md. (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business At Home

FATHER 12. Name John K. Kelley

FATHER 13. Birthplace Parsonsburg Md

MOTHER 14. Maiden name Larenia B. Layfield

MOTHER 15. Birthplace Parsonsburg. Md.

16. Informant Mr. John J. Mumford

Address R.D. #1. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 18. 1945 (month) (day) (year)

Cemetery or Crematory Parsonsburg Lloyd Cem.

Location Parsonsburg. Md.

19. Funeral director Holloway & Walter R. Holloway

Address Salisbury Maryland.

19. 3/16/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1945 at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945, to March 15 1945 and that I last saw her alive on March 13 1945

Immediate cause of death	DURATION
Carcinoma Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Lucy A. Deale M. D. or other

Address Salisbury Md Date signed 3-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-6)

03354

CERTIFICATE OF DEATH

Reg. Dist. No. 3-33

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 weeks
Hospital, institution, or street address where death occurred: 309½ Smith St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 401 Smith St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Nannie B. Parsons

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 22, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	25	hrs. min.

9. Birthplace: Salisbury Wicomico Co.
(Town, county, and state)
10. Usual occupation: Saleslady
11. Industry or business: Department Store

FATHER
12. Name: Andrew Parsons
13. Birthplace: Salisbury Md

MOTHER
14. Maiden name: Olevia A. Phillips
15. Birthplace: Salisbury Md

16. Informant: Mrs Walter H. Dryden
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/21/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md

18. Funeral director: The Hill & Johnson Co
Address: Salisbury Md

19. 3/21/45 (Date rec'd by registrar) Harriet E. Jackson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1945 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mch 10 1945 to MARCH 19 1945 and that I last saw h[illegible] alive on MARCH 19 1945

Immediate cause of death	DURATION
CIRRHOSIS OF LIVER	
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: D. Rivers Hanson, M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 3/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

03355

Reg. Diat. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County Wicomico

City or town Pittsville md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Pittsville,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rebecca Parsons.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1st 1863

8. AGE:

Years	Months	Days	If less than one day
81	9	29	..... hrs. ..... min.

9. Birthplace Pittsville Md. (Town, county, and state)

10. Usual occupation House work.

11. Industry or business

FATHER 12. Name Stephen Moore.

13. Birthplace Pittsville, Md.

MOTHER 14. Maiden name Sallie Truitt

15. Birthplace Pittsville, Md.

16. Informant John Parsons, Address Pittsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2- 1945 (month) (day) (year)

Cemetery or crematory Parsons Cemetery,

Location near Pittsville, Md.

16. Funeral director Wm. Bovard Wells, Address Pittsville, Md.

19. Apr 2 1945 Lillian R. Davis Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1945, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 25 1945, to March 30 1945 and that I last saw her alive on 3-30-45 19.....

	DURATION
Immediate cause of death Myocarditis Chronic.	2 & 3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank K. Lewis M.D. M. D. or other

Address Willards Md. Date signed 3-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

03356

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset

City or town Salesbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Frank L. Porter

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Jessie L. Porter

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 11, 1872

8. AGE: Years	Months	Days	If less than one day
73		17	hrs. min.

9. Birthplace Princess Anne, Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name John L. Porter

13. Birthplace Princess Anne, Md.

MOTHER 14. Maiden name Amanda Lankford

15. Birthplace Princess Anne, Md.

16. Informant Mrs. Frank Porter

Address Princess Anne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1945 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Princess Anne, Md.

18. Funeral director Dale Hadsell

Address Princess Anne, Md.

19. 3/30/45 (Date rec'd by registrar) T. J. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1945, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19~~ ~~to~~ ~~19~~ and ~~that I last saw him~~ ~~alive on~~ ~~19~~

Immediate cause of death	DURATION
Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 3/28/45

Where did injury occur? Princess Anne (City or town) Somerset (County) Md. (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Kerosene Injured at work? No

23. SIGNATURE Mary M. Lankford M.D.

M. D. or other

Address Princess Anne, Md. Date signed 3/29/45

M. LANKFORD, M.D.
Deputy Medical Examiner
for Somerset County

HENRY

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 9 4 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03357

Reg. Dist. No. 332

1. PLACE OF DEATH:
County: Wicomico
City or town: Pauelville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Pauelville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no Street or Number
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Floyd Clarence Pawell

3.(b) Social Security Number: 214-12-5116

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Virginia Pawell
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Dec 15, 1910 19-19-

8. AGE:

Years	Months	Days	If less than one day
34 -26-	3	2	...hrs. ...min.

9. Birthplace: Pauelville, Md.
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Basket
FATHER 12. Name: Clarence Pawell
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary E. [redacted] Parker
15. Birthplace: Md.
16. Informant: Margaret Pawell
Address: Pauelville Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof: Mar. 19, 1945 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Pauelville, Md
18. Funeral director: M. Sacks Watson
Address: Salisbury, Del.
19. (Date rec'd by registrar) Mar. 18 1945 Lillian R. Davis Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 33 to day of death and that I last saw him alive on 3-17-45 19...

Immediate cause of death	DURATION
Carcinoma of Rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank K Lewis M.D.
M. D. or other
Address: Hebron Md. Date signed: 3-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-E)

03358

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Marylnnd County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 N.Division
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Otis Powell

3.(b) Social Security Number: 716-03-1694

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Cora Esther Powell
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 23,1867

8. AGE: Years	Months	Days	If less than one day
77	6	9	...hrs. ...min.

9. Birthplace: Princess Anne, Maryland (Town, county, and state)
10. Usual occupation: Retired Railroad Brakeman
11. Industry or business: Pennsylvania Railroad

FATHER
12. Name: Joshua Thomas Powell
13. Birthplace: Somerset County, Maryland

MOTHER
14. Maiden name: unknown
15. Birthplace: Somerset County, Maryland

16. Informant: J.Elmer Powell
Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar.4-1945 (month) (day) (year)
Cemetery or crematory: Manokin
Location: Princess Anne, Maryland
18. Funeral director: W.S. Ward Co
Address: Delmar, Delaware

19. 3/3/45 Hassie E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2nd 1945 at 10.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on 3/2 19 45

Immediate cause of death	DURATION
Uraemia	1 week
Due to Chronic Nephritis	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward Fisher M.D. M. D., or other
Address: Salisbury, Md. Date signed 3/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03359

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Maggie F. Richardson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Upshur Richardson

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): August 2, 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	5	24		

9. Birthplace: Mathews Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: Sallie Gale
15. Birthplace: unknown

16. Informant: Upshur Richardson

Address: Pocomoke, Maryland R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 29 1945 (month) (day) (year)

Cemetery or crematory: Bethany M. E. Cemetery

Location: Pocomoke City, Md.

18. Funeral director: Margarette B. Walker

Address: Pocomoke City, Md.

19. 3/29 1945 (Date rec'd by registrar) Harriet T. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1945, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1945, to March 26, 1945, and that I last saw her alive on March 25, 1945.

	DURATION
Immediate cause of death: Lobar Pneumonia	3 days
Due to: Pulmonary Tuberculosis	Several years
Due to:	
Due to:	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Peritonitis

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Elmer T. Tomlinson, M.D. or other

Address: Salisbury, Md. Date signed: 3/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03360

Reg. Diat. No. 333

1. PLACE OF DEATH
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 120 years
Hospital, institution, or street address where death occurred: 415 Dairs St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Dairs St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lee Dean Shockley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Elizabeth Shockley

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 29-1873

8. AGE: Years 71 | Months 10 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace: Wicomico Co. Md (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Retired

FATHER
12. Name: Ratliff Shockley
13. Birthplace: Wic. Co. Md

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mr. Clarence Shockley
Address: 313 Hastings St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28 45 (month) (day) (year)
Cemetery or crematory: Parsons Gen.
Location: Salisbury Md

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md

19. (Date rec'd by registrar) 3/28/45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 19 45 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 45 to Mar. 26 19 45 and that I last saw h[illegible] alive on March 26 19 45

Immediate cause of death	DURATION
C.V. Vas. Hem.	6 hrs
Due to Old Int. Nephritis	2 yrs
Due to Arte. Sclerosis	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: H. Long M.D. M. D. or other
Address: Salisbury Md Date signed: 3/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

03361

CERTIFICATE OF DEATH

Reg. Dist. No. 399

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: P. T. Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 413 Washington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Edith C. Shores

3. (b) Social Security Number: 213-24-0850

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ernest C. Shores
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept 22, 1888

8. AGE:

Years	Months	Days	If less than one day
56	6	9	hrs. min.

9. Birthplace: Somerset Co Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Rufus L. Bozman
13. Birthplace: Somerset Co, Md

MOTHER
14. Maiden name: Mary B. Bozman
15. Birthplace: Somerset Co Md

16. Informant: Ernest C. Shores
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md

16. Funeral director: The Hill & Johnson Co
Address: Salisbury Md

19. 3/6 (Date rec'd by registrar) 1945 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/24 1945, to 3/3 1945
and that I last saw h[illegible] alive on 3/3 1945

Immediate cause of death: Coronary Sclerosis — DURATION:
Due to: Uremia
Due to:
Other conditions: C of Heart,
(Include pregnancy within 3 months of death)

Major findings of operations: C of Heart — Date of op. 2/28/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: N/A — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury — Date signed 3/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

03362

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 5 years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 645 W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Samuel Smith

3. (b) Social Security Number: Don't Know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Don't know

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1888

8. AGE: Years	Months	Days	If less than one day
about 57	—	.	...hrs. ...min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above
FATHER — 12. Name: Unknown
FATHER — 13. Birthplace: Unknown
MOTHER — 14. Maiden name: Unknown
MOTHER — 15. Birthplace: Unknown
16. Informant: Chief of Police Wm. F. Chatterton
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 27 1945 (month) (day) (year)
Cemetery or crematory: Public
Location: Salisbury Md
18. Funeral director: James D. Stewart
Address: Salisbury Md
19. 3/27/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about March 17 1945 at Unknown

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from last 19 to 19 and that I last saw h[illegible] alive on [illegible] 19

Immediate cause of death	DURATION
Drowning	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of about 3-17-45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?): River
Means of injury: Probably fell in water. Injured at work? No
How injury occurred: Fell overboard from [illegible]

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury Md Date signed 3/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

03363

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 9 hrs. 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Paul Henry Stephenson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Child

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1944

8. AGE:

Years	Months	Days	If less than one day
	6	7	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business

FATHER 12. Name: Paul S Stephenson

FATHER 13. Birthplace: Maryland.

MOTHER 14. Maiden name: Marcella Downey.

MOTHER 15. Birthplace: Marionville Va.

16. Informant: Mr. Paul S Stephenson

Address: Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/45 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md.

18. Funeral director: Franklin B. Hall

Address: Salisbury Md.

19. 3/28 1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 26 1945 to March 27 1945 and that I last saw h. i. m. alive on March 27 1945

Immediate cause of death	DURATION
Acute Bronchial	
Due to: Pneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Rivers Hanson M.D.

M. D. or other

Address: Salisbury, Md. Date signed 3/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03364

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 600 Race
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Josephine Pradwen

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a. a.	widowed

6.(b) Name of husband or wife: Charles Pradwen

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1872

8. AGE: Years	Months	Days	If less than one day
about 72			....hrs. ....min.

9. Birthplace: Salisbury Md
(Town, county, and state)

10. Usual occupation: housekeeper

11. Industry or business: no

FATHER
12. Name: Sandy Hoskins

13. Birthplace: Baltimore md

MOTHER
14. Maiden name: Elsworth

15. Birthplace: Maryland

16. Informant: John Pradwen

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: mar 26 - 1945 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. 3/26/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 23 1945 at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Mar 23 1945 and that I last saw h[illegible] alive on Mar 1 1945

Immediate cause of death	DURATION
Cerebral hypertension	2 mo +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other

Address: Salisbury Md Date signed: Mar 24

03365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Camden Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Waller, Emma Virginia

3. (b) Social Security Number: ✓

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
6. (b) Name of husband or wife: Henry J. Waller
6. (c) If alive, give age: ✓ years
7. Birth date of deceased (mo., day, yr.): May 16, 1858

8. AGE: Years	Months	Days	If less than one day
86	9	13	........hrs. ....min.

9. Birthplace: Wicomico Co., Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: ✓
FATHER 12. Name: Robert W. Ellegood
FATHER 13. Birthplace: Somerset Co., Md.
MOTHER 14. Maiden name:
MOTHER 15. Birthplace:
16. Informant: Robert W. Waller,
Address: Salisbury, Md.
17. Burial — Date thereof: 3/3/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.
19. 3/3, 1945 Harriet E. Johnson, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1945, at 9:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1945, to Feb. 22, 1945
and that I last saw h[er] alive on Feb. 28, 1945

	DURATION
Immediate cause of death: Senile degeneration	7 days
Due to: Fracture & dislocation of left shoulder	9 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Fracture dislocation of left humerus — Date of op. 2/16/45
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident — Date of: 2/16/45
Where did injury occur? Salisbury, Wicomico, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: fell on shoulder — Injured at work? No

23. SIGNATURE: J. G. Rasterwalter MD, deputy Med. Examiner — M. D. or other
Address: Salisbury, Md. — Date signed 3/1/45

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

03366

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred: 1208 W. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1208 W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Henry White

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Annie P. White
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Jan. 22-1860

8. AGE: Years	Months	Days	If less than one day
85	1	29	hrs. min.

9. Birthplace: Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Thomas R. P. S. White
13. Birthplace: Worcester Co. Md.
MOTHER 14. Maiden name: Lucie Mills
15. Birthplace: Worcester Co. Md.
16. Informant: Mrs. Elisha Nichols
Address: 1208 W. Main St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 23-1945 (month) (day) (year)
Cemetery or crematory: M.E. Cemetery
Location: Snow Hill Maryland
18. Funeral director: Wilkinson & Walter P. Wilkinson
Address: Salisbury Maryland.
19. 3/23/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21st 1945 at 4.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to Mar 21 1945 and that I last saw h... alive on Mar 21 1945.

Immediate cause of death	DURATION
(a) Chr. Valv. Heart.	6 mos.
Due to (b) Chr. Inf. Nephritis	7 yrs.
Due to (c) Artio. Sclerosis	24 yrs.
Other conditions: Dermatitis (Include pregnancy within 3 months of death)	2 wks.

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: W. O. Lewis M.D. M. D. or other
Address: Salisbury Md. Date signed: 3/23/45

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

03367

Reg. Dist. No. 338

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred: 201. Pine St.,

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 201. Pine St. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Leah Emily Willing

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Female	White	Widow

6.(b) Name of husband or wife George Willing

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 29. 1870

8. AGE:

Years	Months	Days	If less than one day
75	1	3	..... hrs. ..... min.

9. Birthplace Damascus Quantico Md. (Town, county, and state)

10. Usual occupation House work

11. Industry or business at Home

FATHER — 12. Name James Webster

FATHER — 13. Birthplace Damascus Quantico Md.

MOTHER — 14. Maiden name Elizabeth Bozman

MOTHER — 15. Birthplace Somerset Co. Md.

16. Informant Mrs. Durand Jenkins

Address 110 Foster St. Salisbury Md

17. Buried Date thereof March 5 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Maryland

18. Funeral director Hollowell & Walter R. Hollowell

Address Salisbury Maryland

19. 3/5/45 Gabriel E. Johnson Reg. Dist.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3-1945 at 12.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 1945 to March 3 1945

and that I last saw her alive on March 3 1945

Immediate cause of death	DURATION
Cerebro arteriosclerosis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wanner M.D.

Address Salisbury Md. M. D. or other

Date signed 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03368

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Luther Wise

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lena Wise

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): December 7, 1875

8. AGE: Years	Months	Days	If less than one day
69	3	3	...hrs. ...min.

9. Birthplace: Accomack Va (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ~~Farmer~~

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Va

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: ~~Unknown~~

16. Informant: Ella Thomas

Address: Marsh Market Va.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: March 13/45 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Pocomoke Va.

18. Funeral director: Keane & Simmons

Address: Snow Hill Md

19. 3/10/45 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1945, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1945, to March 10 1945

and that I last saw h.. alive on March 9 1945

Immediate cause of death	DURATION
Gunshot Wound	
Due to: Ruptured appendicitis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles A Fowler M. D. or other

Address: Date signed